ADULT DAY HEALTH CARE CENTER
LEVEL II REIMBURSEMENT DETERMINATION FORM

An Adult Day Health Care (ADHC) provider may apply for Level II reimbursement if eighty (80) percent of those individuals receiving services on a "SNAP SHOT" day determined by DMS and based on an average daily census of at least twenty (20) individuals enrolled in the ADHC (limited to: Home and Community Based Waiver clients, private pay or covered by insurance and diagnosed as having:

> **A disability that manifested itself before the age of twenty – two (22) that is attributable to mental retardation or cerebral palsy, epilepsy, autism or neurological conditions that results, in an impairment of general intellectual functioning or adaptive behavior. This neurological condition should significantly limit the individual in two (2) or more of the following skilled areas: communication, self-care, home-living, social skills, community use, self direction, health and safety, functional academics, leisure, work and limitation similar to that of a person with mental retardation, this limitation should result directly from or is significantly influenced by substantial cognitive deficits. The limitation may not be attributable to only a physical or sensory impairment or mental illness.**

Provider Name: _____ **Provider #:** _____
Street Address: _____ **Phone #** ___ - ___ - ____
City, State, Zip Code: _____

"SNAP SHOT" DATE: _____ / _____ / _____
(Month) (Day) (Year)

Average daily census shall be limited to those individuals designated as Home and Community Based Waiver, private pay or covered by insurance. (This definition does NOT include any individuals who are designated as or otherwise described by and of the following: NF/PASRR, SCL, ABI, EPSDT, or other Medicaid Waiver Program:

AVERAGE DAILY CENSUS: _____

Please complete the following for each client in the ADHC that meets the criteria for Level II reimbursement.

NAME	MAID # IF APPLICABLE	DATE OF BIRTH	DIAGNOSIS	DATE OF ONSET

I VERIFY THE ABOVE INFORMATION IS ACCURATE

(SIGNATURE) **(DATE)**

Mail orginal to:
Attention: HCB Waiver Supervisor
Health Care Review Corporation
9200 Shelbyville Road, Suite 800
Louisville, KY 40222

Mail Copy to:
Department for Medicaid Services
Division of Long Term Care
275 E. Main St., 6WB
Frankfort, KY 40621

If additional space is needed, please attach as many addendum pages as necessary.

NAME	MAID # IF APPLICABLE	DATE OF BIRTH	DIAGNOSIS	APPX DATE OF ONSET

I verify the above information is accurate. (Initial)____ (Date) _____